Pennsylvania Flex Program

Fiscal Year (FY) 2019 Significant Accomplishments, Best Practices, and Lessons Learned

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Program Area 1: CAH Quality Improvement

Historically, Pennsylvania has been a leader in health care quality improvement (QI). In 2016, the Pennsylvania Office of Rural Health (PORH) hired a full-time QI coordinator to dedicate targeted efforts toward critical access hospital (CAH) QI initiatives. PORH's QI Coordinator spends significant time providing training and technical assistance for CAH QI d irectors and the outcomes are evident.

In 2017 and 2018, the Flex Monitoring Team ranked Pennsylvania in the top-five state rankings for CAH reporting rates for Medicare Beneficiary Quality Improvement Project (MBQIP) inpatient and outpatient quality measures. In 2019, the Pennsylvania Flex Program was ranked #1 in the country by the Flex Monitoring team and FORHP in recognition of the State's consistent 100percentCAH reporting rate for inpatient and outpatient quality measures. For the FY19 Flex period of performance, Pennsylvania CAHs continued to achieve 100 percent reporting rates for these measures.

For the FY19 Flex period of performance, it was PORH's goal to continue to be a leader in assisting CAHs in providing exceptional care transitions and increasing the state's composite measure to above 90 percent. PORH's QI coordinator continued to work closely with the CAHs to implement best practices to improve their EDTC reporting. All CAHs have implemented policies and procedures, and embedded toolkits into their EHR with built-in reminders for specific patient care protocols. Each CAH's Emergency Department (ED) manager compiles all EDTC data, identifies trends, and reviews any areas for improvement. ED managers hold quarterly meetings to discuss EDTC data results and develop improvement initiatives and post

EDTC tracking reports for continuous staff review. One of the CAHs held a monthly "maximizing optimal patient outcomes" ice-cream social to discuss successes, challenges, and strategies for improvement.

Using Stratis Health's tool, PORH's QI coordinator now collects and submits Pennsylvania's EDTC data. During the February 2020 virtual meeting of the Pennsylvania CAHs, Stratis Health gave a webinar on the new tool and EDTC best practices. Stratis Health continues to be a significant resource for PORH and state's CAHs for any questions or issues with the EDTC collection process.

These efforts resulted in significant EDTC performance improvement for Pennsylvania's CAHs. For all four quarters in 2019, Pennsylvania CAHs achieved 100 percent EDTC participation and the State's composite score was at or above 90 percent for each of those four quarters.

Lessons Learned During this Activity

PORH's hiring of a full-time QI coordinator is the most significant best practice for Pennsylvania for this program area. Additional best practices implemented by PORH's QI coordinator and the CAH QI directors include:

- Review, evaluation, and sharing of MBQIP reports with CAH leadership;
- Evaluation of hospital, state, and national data to establish benchmarks and performance goals;
- Presentation and use of Stratis Heath's EDTC best practices, and sharing of successful Pennsylvania EDTC program best practices within the state's CAH network; and
- Utilization of EDTC mentors to help other CAHs to facilitate improvement.

PORH recommends this activity and utilizing the tools and resources provided by Stratis Health. This guidance supports a clear understanding of the EDTC purpose and process, and outlines a thorough blueprint for success in maximizing optimal patient outcomes.

Program Area 2: CAH Operational and Financial Improvement

For Pennsylvania CAHs, no other activity conducted by PORH and the Pennsylvania Flex Program is as significant to the CAHs as the effort focused on the Medicaid supplemental funds provided by the Commonwealth of

Pennsylvania. Since 2010, this program has resulted in over $194M in revenue for the State's CAHs.

Throughout the year, Pennsylvania's CAHs are reimbursed at the prospective payment system (PPS) hospital reimbursement rate for services provided to Medicaid patients, rather than 101 percent of the CAHs' costs. PORH contracts with a retired Pennsylvania CAH CEO/CFO to calculate the shortfall amount for Medicaid services provided by the CAHs using the Medicaid Cost Report. This calculation is provided to the Pennsylvania Department of Human Services (DHS), the State's Medicaid Agency, which audits the report. After the total is validated, the Hospital and Healthsystem Association of Pennsylvania (HAP) advocates through the State legislature for the total funding required to ensure compliance with the federal match through the Centers for Medicare and Medicaid Services (CMS). Most years, the entire CAH Medicaid shortfall amount is reimbursed at 101 percent of each CAH's Medicaid costs in April of the following year. In April 2020, the 15 Pennsylvania CAHs received just under $29M. In July 2020, an additional CAH was designated in Pennsylvania for a total of 16 CAHs that will participate in this program for 2021.The expected revenue for the upcoming year from this activity will be just over $31 million to be paid in April 2021.

Lessons Learned During this Activity

Since the inception of this activity, PORH has engaged the services of a highly experienced, retired CAH CEO/CFO who established strong relationships with CAH leadership and HAP, and developed a strong methodology for the Medicaid supplemental process. HAP and DHS collaborated on, and approved, this methodology in 2010 and it is still the process used today. This consultant's experience and established trust with the CAHs, HAP, and DHS has been key to making this a seamless and successful process each year. The consequences of not utilizing this experienced and trusted resource with a decade of direct experience with this process and project could potentially result in the loss of, or decreased, annual funding for Pennsylvania's CAHs.

PORH believes this activity is essential to maintaining a successful Flex Program in Pennsylvania; however, may not be easily transferrable to other states. Pennsylvania's Medicaid supplemental process and key stakeholders are very specific to the Commonwealth, but this activity could be used as a general guide to initiate similar processes in another states.

Program Area 3: CAH Population Health Improvement

PORH has partnered with the Pennsylvania Department of Health for nearly a decade and the newly created Pennsylvania Rural Health Redesign Center Authority to assist with the planning, development, and implementation of the Pennsylvania Rural Health Model(PA RHM). The PA RHM is the first alternative payment model in the country focused entirely on rural hospitals.

The model, which launched on January 1, 2019, with five participating rural hospitals (three CAHs), four commercial payers, and Medicare, seeks to address the financial challenges faced by rural hospitals by transitioning them from fee-for-service to global budget payments. Doing so aligns incentives for providers to deliver value-based care and smooths cash flow so hospitals receive a consistent monthly payment that is not tied to volume.

Over the past few years, PORH has utilized Flex funding to support CAH recruiting and transformation plan implementation for the PA RHM. There are currently five CAHs participating in the Model. As a requirement for participation in the PA RHM, each hospital must create a transformation plan specifying how they will move from a volume to value focusing on the specific population health challenges in their communities.

In order for hospitals to succeed financially under the model, they must reduce potentially avoidable utilization (PAU), which is driven by readmissions and inappropriate use of the emergency department. In many of the hospital transformation plans, a need for care management to effectively address high-cost, high-need (HCHN) patients was identified. This presented an opportunity for the hospitals to collaborate and think strategically about who could assist these patients in greatest need, both to achieve best patient outcomes and to help the hospital succeed under the model.

Participating hospitals identified Chronic Obstructive Pulmonary Disease (COPD) as a chronic care management opportunity and have agreed to work as a cohort to collaborate and develop best practices. For the FY19 period of performance, PORH utilized Flex funding to assist CAHs in prevention and management activities for COPD. The PA RHM team worked with Quality Insights to develop an online COPD training platform for providers to assist the cohort with achieving their goals. The expected outcome of this training is to improve the knowledge of providers on successful practices for COPD prevention, and better care coordination and management of COPD patients to improve quality of life and patient outcomes.

Lessons Learned During this Activity

The overwhelming best practice that has come out of the PA RHM is the utilization of hospital cohorts. Participating hospitals develop cohorts with other hospitals with similar transformation planning goals. Work groups have been formed in the areas of social determinants of health, substance use disorder, behavioral health, care coordination and chronic care management (to include COPD), operational efficiencies, transportation, and telehealth. Hospitals communicate their issues and challenges and collaborate to vet ideas and develop potential solution.

The most significant lesson learned inworking with the PA RHM participating hospitals is that everything takes longer than expected. Because the Model is the first of its kind for rural hospitals, many issues and challenges have to be continuously addressed and resolved as implementation is occurring. The PA RHM team often refers to this as "building the plane while flying it."

PORH recommends this engagement and any engagement that encourages rural health care facilities to move from volume to value. The PA RHM has been a great opportunity for the Commonwealth and has brought significant attention to global budgeting and health care transformation initiatives. Even hospitals that are not directly participating in the model are benefitting from the state's focus on value-based care and training opportunities.

Program Area 5: Innovative Model Development

The Practice Operations National Database (POND) from Lilypad is a web-based practice benchmarking application designed specifically for rural health clinics (RHCs). POND provides an avenue for RHCs to share blinded financial, operational, productivity, and compensation data. Once a RHC enters their practice data into POND, they have access to blinded benchmark data which can be utilized to guide practice improvements. These data also give the SORH information from which tailored technical assistance can be planned.

In 2017, PORH subscribed to POND, making it available to all RHCs in Pennsylvania but had little success recruiting RHCs for participation. In 2018, PORH's Dental Delivery System Coordinator became a Certified Rural Health Clinic Professional and provided support to RHCs in three different health systems on billing, coding, administration, and the use of POND. At that time, there were 70 RHCs in Pennsylvania, and only two were enrolled in POND.

In 2019, PORH planned to recruit an additional eight RHCs for a total of 10 enrolled and actively participating in POND by the end of FY19. PORH engaged with both Lilypad and the National Organization of State Offices of Rural Health (NOSORH) on their Tailored Technical Assistance Program to assist with providing customized financial and operational technical assistance for Pennsylvania RHCs. This program allowed PORH to assist one RHC with compilation of their cost report, essentially training new finance staff. PORH also assisted another RHC with MCO enrollment for a dental provider. The Dental Delivery Systems Coordinator partnered with The Compliance Team to learn more about RHC Surveys and to learn how to assist RHCs by conducting mock surveys. Unfortunately, just as the Dental Delivery Systems Coordinator acquired this knowledge, COVID-19 prevented travel across the State.

In November 2019, PORH hosted the first Rural Health Care Transformation Summit attended by small rural hospital and RHC leadership to focus on the transition from volume to value. This first summit was very successful and was attended by20 RHC leaders. The RHC afternoon breakout session was tailored to RHC relevant topics, including a National RHC update presented by the National Association of Rural Health Clinics (NARHC) and a presentation on POND. Positive feedback was received by participants and the Dental Delivery Systems Coordinator was able to build a more robust RHC email distribution list. This distribution list proved to be invaluable and was used by the Dental Delivery Systems Coordinator to communicate regular updates regarding COVID and other important rural-relevant information on a regular basis. Participant feedback from the summit also recommended the addition of RHC leadership at all PORH quarterly meetings which was implemented for all future meetings.

PORH included RHC leadership in every quarterly CAH Consortium meeting for FY19 which included morning plenary sessions for all health care leaders and separate afternoon breakout sessions for RHC leadership, QI Directors, and hospital leadership. PORH's 2020 Rural Health Care Transformation summit was held virtually in October and was even more successful with 26 RHC leaders attending. Following a presentation at the February 2020 meeting focused on finance, RHC leaders requested additional education related to RHC billing and coding. While this training was being planned, RHCs were impacted by COVID. As many preventive visits were canceled, billers and coders had lighter schedules. PORH made use of this time by offering an RHC billing and coding bootcamp in partnership with Arch Pro Coding. The two-day event was held virtually and was attended by 60 individuals. Positive feedback was received regarding this event and PORH was able to provide the training at no cost to the attendees.

For the FY20 Flex program, RHCs will continue to be included in all meetings and summits. Additionally, PORH has engaged Stroudwater Associates, to present seven, virtual, one-hour, financial and operational webinars to CAH and RHC leadership on topics including:

- CAH/RHC 101;
- Leveraging RHCs to Expand Behavioral Health Services;
- Pennsylvania RHC Best Practices and Benchmarks;
- Transitioning to a Performance Improvement Executive Committee;
- Care Spectrum Creation, the Use of Market Analytics to Drive Decision-Making; and
- Affiliation Value Curve.

Lessons Learned During this Activity

It is important to engage RHC leadership and to offer tailored technical assistance by reaching out, providing targeted assistance, and following through to build trust. Once RHC leaders learn about the SORH and available resources, they are more willing to engage. RHCs are not quick to adopt POND and it is important to demonstrate the value of participation. PORH had the most engagement in POND following an in-person session with Lilypad which gave real examples of how the data in POND can benefit an RHC.

RHC engagement is an important aspect of a SORH's work since these clinics play an important role in promoting the health of rural communities. Supporting RHCs in ensuring program compliance and providing assistance with the fiscal issues ensures that RHCs remain viable and provided high quality accessible care.